MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Allied Health • Orthotics and Prosthetics

June 2007 • Bulletin 381

Contents

2007 HCPCS Updates for DME and O&P: Implementation August 1, 2007

The 2007 updates to the Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after August 1, 2007. Specific policy changes are detailed below.

DURABLE MEDICAL EQUIPMENT

Deleted and Replacement Codes

The following are deleted codes and replacement codes based on Noridian Administrative Services, Medicare's contractor for Durable Medical Equipment (DME). The policy of the deleted codes applies to the replacement codes unless otherwise noted.

Deleted Code(s)	Replacement Code(s)
E0164	E0163
E0166	E0165
E0180	E0181
E0701	A8000, A8001
E2320	E2373 (modifier KC is not applicable)
K0090	E2381, E2386, E2390 (frequency restriction has changed)
K0091	E2382 (frequency restriction has changed)
K0094	E2384, E2387, E2391
K0095	E2385

Billing Restrictions

HCPCS codes A8000, A8001 (prefabricated helmets), A8002 and A8003 (custom helmets) and A8004 (replacement interface) will be Medi-Cal benefits. Codes A8000 – A8004 are reimbursable to physicians, certified orthotists and prosthetists, and California Children's Services (CCS) providers; codes A8000, A8001 and A8004 are reimbursable to DME providers. These items are not rented (modifier RR is not allowed); claims for A8000 – A8004 must be billed as a purchase (modifier NU) or repair (modifiers RPNU) only. Claims for code A8004 must include documentation that the patient owns the helmet. Codes A8000, A8001 and A8004 are taxable items. Codes A8000 – A8004 are all subject to the orthotic cumulative per-month *Treatment Authorization Request* (TAR) threshold of $250.

Mobile commode chairs previously billed with terminated HCPCS codes E0164 (fixed arms) and E0166 (detachable arms) must now be billed with revised mobile or stationary commode chair code E0163 (fixed arms) and activated code E0165 (detachable arms).

Replacement commode pail/pan HCPCS code E0167 is a purchase-only item (modifier NU). Claims must include documentation that the patient owns the commode. Labor is not separately reimbursable for replacing this item.

Please see **HCPCS**, *page 2*

HCPCS *(continued)*

Alternating pressure pads previously billed with terminated HCPCS code E0180 must now be billed with revised code E0181 (powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty). The rental rate for code E0181 has been adjusted from $18.34 to $20.85.

The description of HCPCS code E0182 has been revised from "pump for alternating pressure pad" to add the words "for replacement only." This item must now be billed as a purchase-only (modifier NU); labor for replacement is not payable. The *Reserved for Local Use* field (Box 19) of the claim must document that the patient owns the alternating pressure pad.

New HCPCS code E0936 (continuous passive motion exercise device for use other than the knee) is a rental-only code and must be billed with modifier RR (rental). The established reimbursement rate includes payment for all accessories. The device is a taxable item.

HCPCS codes E2374 – E2376 and E2381 – E2396 (power wheelchair accessories) may only be reimbursed as purchased replacement items for patient-owned equipment. They are not separately reimbursable with the initial purchase of codes K0813 – K0891 (Group 1 – 5 power wheelchairs). Claims must be billed with modifier RPNU (labor for replacement is allowed). Documentation of the patient-owned equipment these accessories are applied to must be included in the *Reserved for Local Use* field (Box 19) of the claim.

HCPCS code E2377 (power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue) may be reimbursed separately with the rental or initial purchase of wheelchair codes K0835 – K0891. This code will only be reimbursed as a purchase or rental (modifiers NU or RR). Labor is not separately reimbursable for this upgrade.

Existing HCPCS code T5001 (special orthotic positioning seat) will now be a Medi-Cal benefit, subject to prior authorization. Reimbursement will be "By Report." Code T5001 must be billed with modifier NU (purchase), RR (rental) or RP (repair). Claims billing for repair of this item with modifier RP must document that the patient owns the positioning seat. Separate reimbursement for labor is allowed for the repair of patient-owned equipment. This device is a taxable item.

Purchase Frequency Restrictions
Codes A8000, A8001 and A8004 are limited to one in 12 months.

Codes E0165, E0936, E2373 – E2377, K0800 – K0898 and T5001 are limited to one in three years.

Codes E2381 – E2396 are limited to six in 12 months.

All of the above restrictions apply to any provider.

ORTHOTICS AND PROSTHETICS

Deleted and Replacement Codes
The following are deleted codes and replacement codes based on Noridian Administrative Services, Medicare's contractor for orthotics and prosthetics (O&P). The policy of the deleted codes applies to the replacement codes.

Deleted Code(s)	Replacement Code(s)
L0100	A8002, A8003
L0110	A8000, A8001
L6700, L6720 –L6370	L6704
L6705, L6710, L6715, L6735 – L6795	L6706
L6800, L6806 – L6808	L6707
L6825, L6835 – L6860, L6867, L6872, L6873, L6880	L6708
L6830, L6875	L6709
L7015	L7008

Please see **HCPCS**, *page 3*

HCPCS *(continued)*

Billing Restrictions
HCPCS codes A8000, A8001 (prefabricated helmets), A8002 and A8003 (custom helmets) and A8004 (replacement interface) will be Medi-Cal benefits. Codes A8000 – A8004 are reimbursable to physicians, certified orthotists and prosthetists, and CCS providers; codes A8000, A8001 and A8004 are reimbursable to DME providers. These items are not rented (modifier RR is not allowed); claims for A8000 – A8004 must be billed as a purchase (modifier NU) or repair (modifiers RPNU) only. Claims for code A8004 must include documentation that the patient owns the helmet. Codes A8000, A8001 and A8004 are taxable items. Codes A8000 – A8004 are all subject to the orthotic cumulative per-month TAR threshold of $250.

HCPCS code L1001 (infant spinal immobilizer) is reimbursable, with prior authorization, for custom-made devices designed for the stabilization of the cervical spine, upper thoracic spine and/or airway of a child younger than one year of age. A CCS denial is required for Medi-Cal authorization. Claims must include an invoice. Coverage of L1001 excludes an infant immobilizer used to restrain infants during surgical or radiological procedures (for example, Circumstraint device for restraint during circumcision).

HCPCS codes L3806, L3808, L3915, L5993, L5994, L6611, L6624, L6639, L6703, L6704, L6706 – L6709, L6805, L6810, L7040 and L7045 may be billed as bilateral appliances.

Prior authorization is always required for codes L1001, L5993, L5994, L6611, L6624 and L6639, and is required for all other codes when the amount billed exceeds TAR thresholds.

Existing HCPCS code T5001 (special orthotic positioning seat) will now be a Medi-Cal benefit, subject to prior authorization. Reimbursement will be "By Report." It must be billed with modifier NU (purchase), RR (rental) or RP (repair). Separate reimbursement for labor is allowed for the repair of patient-owned equipment. Claims billing code T5001 with modifier RP must document that the patient owns the positioning seat. This device is a taxable item.

Purchase Frequency Restrictions
Codes A8000 – A8004, L0631, L1001, L3806, L3808, L3915, L5993, L5994, L6611, L6624, L6639, L6703, L6704, L6706 – L6709, L6805, L6810 and L6884 are limited to one in 12 months.

Codes L5848, L6881, L7007 – L7009, L7040 and L7045 are limited to one in three years.

The manual replacement pages reflecting this policy will be released in the July *Medi-Cal Update.*

Redirection of Treatment Authorization Request Services

Effective July 1, 2007, several regionalized *Treatment Authorization Request* (TAR) services provided by the Fresno Medi-Cal Field Office (FMCFO) are being redirected to the Northern and Southern Pharmacy Sections (NPS and SPS), Sacramento Medi-Cal Field Office (SMCFO) and San Francisco Medi-Cal Field Office (SFMCFO).

TAR services currently handled by the FMCFO will be redirected as follows:

- Intravenous home infusion equipment services, including all medical supplies related to infusion therapy, and all Durable Medical Equipment (DME) and medical supplies related to enteral feeding, have been redirected to the NPS and SPS.
- Medical supplies related to incontinence, including urinary catheters and bags, have been redirected to the SMCFO.
- Breast pumps and supplies have been redirected to the SFMCFO.
- Physician-administered drugs and/or physician-performed services/procedures, radiology services, inpatient and outpatient surgeries and procedures that require a TAR and elective acute hospital admissions have been redirected to the SMCFO.

Please see **Redirection**, *page 4*

Redirection *(continued)*

Providers located in Oregon border cities were required to submit their TARs, for core services only, to SMCFO effective May 1, 2004.

The California Department of Health Services (CDHS) does not anticipate any delays in adjudication of these TAR types. Manual replacement pages will be released in a future *Medi-Cal Update.*

Processing Changes for Treatment Authorization Requests

Beginning May 1, 2007, the California Department of Health Services (CDHS) started phasing in several changes that impact how paper *Treatment Authorization Requests* (TARs) are processed.

These changes are being implemented to minimize the key data entry of incomplete or erroneous TAR information and to reduce the volume of paper documents containing Protected Health Information (PHI), particularly Social Security Numbers (SSNs) that are sent via:

- United States Postal Service
- Courier services
- Other types of delivery services

CDHS expects to complete this phased implementation by September 2007.

Processing Change Schedule
Processing changes to paper TARs impact providers interacting with the Medi-Cal field offices and pharmacy sections on the following dates:

May 2007 Sacramento Medi-Cal Field Office	**August 2007** Fresno Medi-Cal Field Office San Bernardino Medi-Cal Field Office San Diego Medi-Cal Field Office San Francisco Medi-Cal Field Office
June 2007 Northern Pharmacy Section (Stockton) Southern Pharmacy Section (L.A.)	
July 2007 L.A. Medi-Cal Field Office In-Home Operations South	**September 2007** TAR Administrative Remedy Section In-Home Operations North

Incomplete TARs
CDHS Medi-Cal field offices and pharmacy sections will be unable to enter paper TARs with incomplete information into the TAR system. These paper TARs will be deferred back to the submitting provider, with a Medi-Cal field office/pharmacy section *Incomplete TAR Form* identifying the reasons for deferral and instructions about how to resubmit the paper TAR with the necessary corrections.

Providers are to:

- Make the necessary corrections/changes on the paper TAR, and
- Resubmit with a copy of the *Incomplete TAR Form* on top of the paper TAR.

Paper TARs that are returned to the submitting provider for correction will not be available for inquiry through the Provider Telecommunications Network (PTN).

Any one of the reasons below will not allow the paper TAR information to be entered into the system. The reason(s) will be marked on the *Incomplete TAR Form* and sent back to the submitting provider for corrections. These reasons may consist of one or more of the following:

- The TAR form is illegible or damaged.
- The submitting provider number is missing, inactive, suspended or invalid for the category of service requested.

Please see **Processing Changes**, *page 5*

Processing Changes *(continued)*

- The patient's Medi-Cal ID number is missing, invalid or invalid in length, and the patient's name/date of birth is missing.
- The patient is not Medi-Cal eligible.
- Information in the *Admit From* field (Box 14) on the *Long Term Care Treatment Authorization Request* (LTC TAR, form 20-1) is missing or invalid.
- The requested service information is missing, invalid or invalid in length.
- The ICD-9-CM diagnosis code, admitting ICD-9-CM diagnosis code and/or primary DX diagnosis code is missing or invalid.
- The County Medical Services Program (CMSP) pharmacy services are covered by MEDIMPACT. Providers may call 1-800-788-2949 for further information.
- The requested Adult Day Health Care (ADHC) service should specify the months and the number of requested days for each calendar month on separate lines of the TAR. The TAR request should not exceed six months or have more than one service line for a given calendar month. Providers may refer to the appropriate Part 2 manual for specific TAR preparation instructions.

Adjudication Response
CDHS will discontinue the practice of returning adjudicated paper TAR copies to providers based on the schedule above. Instead, providers will receive an *Adjudication Response* (AR), which will display:

- The status of requested service(s)
- The reason(s) for the decision(s), including TAR decisions resulting from an approved or modified appeal
- The adjudicator's request for additional information, if necessary

The AR will enable the provider to respond to the requested information or proceed to bill for authorized services. (See the *Adjudication Response* example at the end of this article.) Providers should keep a copy of the AR for their records and use it when responding to deferrals or when requesting an update/correction to a previously approved or modified TAR.

When requesting an update/correction, a copy of the AR must be placed on top of newly submitted documents to ensure the information can be matched with previously submitted documentation. Providers should clearly specify what change(s) are being requested.

The ARs will be mailed to the provider's address on file with CDHS' Payment Systems Division, Provider Enrollment Branch (PEB). Providers should ensure PEB has their most up-to-date mailing address on file. Instructions about changing/updating a provider address may be found on the Medi-Cal Web site (**www.medi-cal.ca.gov**). From the home page, click the "Provider Enrollment" link and then the "Provider Reminders" link at the top of the page.

Attachments
On November 15, 2006, CDHS notified providers via a flyer that attachments were no longer being returned with deferred paper TARs. Medi-Cal field offices and pharmacy sections will continue to retain and archive all attachments for reference.

Providers responding to a deferred TAR should return the AR and any new attachment(s) requested.

SSN on TARs
In accordance with *Medi-Cal Updates* issued in August and September 2006, providers should use the recipient's Benefits Identification Card (BIC) number on the TAR, rather than the SSN. If a TAR is returned to a provider because of inaccurate and/or incomplete information, the SSN will be removed.

Provider questions may be directed to the local Medi-Cal field office or pharmacy section.

Please see **Processing Changes**, *page 6*

Processing Changes *(continued)*

National Provider Identifier (NPI) Number

Providers should be aware that the NPI number will not be accepted on TARs until after the official NPI implementation date of November 26, 2007. For detailed information about the new NPI implementation date, providers can view the "Important NPI Time Frame Changes" article posted in the "HIPAA News" area of the Medi-Cal Web site (**www.medi-cal.ca.gov**).

TARs issued under the old provider number (legacy number) prior to November 26, 2007 can still be used for claims submitted with an NPI starting on or after November 26, 2007. Providers will not have to request an updated TAR with the NPI information.

State of California - Health and Human Services Agency
Department of Health Services

CONFIDENTIAL

Medi-Cal Operations Division

ARNOLD SCHWARZENEGGER, Governor

ADJUDICATION RESPONSE

Provider Number: HSCXXXXXX
XXX CONTRACT HOSP #2
3215 PROSPECT PARK DR
RNCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101
Date of Action: 06/27/2006
Regarding: Jane Doe
TAR Control Number: 9876543210

This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:

Svc #	Service Code	Modifier(s)	Service Description	From Date of Service	Thru Date of Service	Units	Quantity	Status	P.I.
1	123ABC	1	Service Description 1	01-01-2006	01-31-2006	12345	1000000.123	1 Approve	1
2	ABC123	2	Service Description 2	01-01-2006	01-31-2006	12345	1000000.123	2 Modify	0
	Reason(s):	GEN: Modified, refer to comments							
	Comment(s):	Comments from Field Office Consultant 2							
3	ABC123	3	Service Description 3	01-01-2006	01-31-2006	12345	1000000.123	3 Deny	3
	Reason(s):	GEN: Denied, refer to comments							
	Comment(s):	Comments from Field Office Consultant 3							
4	ABC123	4	Service Description 4	01-01-2006	01-31-2006	12345	1000000.123	4 Defer	5
	Reason(s):	GEN: Deferred, refer to comments							
	Comment(s):	Comments from Field Office Consultant 4							

Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service.

If you have received this document in error, please call the Telephone Service Center, 1-800-541-5555 in California, 1-916-636-1200 out-of-state (follow the prompts for eTAR), to notify the sender. Please destroy this document via shredder or confidential destruction.

Medi-Cal Share of Cost and Medicare Part D Reminder

Medicare-eligible recipients with a Medi-Cal Share of Cost (SOC) are not eligible for Medi-Cal benefits until their SOC is met. Under the Medicare Part D prescription drug program, Medicare beneficiaries with a Medi-Cal SOC may have higher prescription drug payment obligations than beneficiaries without an SOC. These payment obligations may include deductibles and copayments.

All medically necessary health services, whether covered by Medi-Cal or not, can be used to meet SOC for Medi-Cal purposes. All prescription drug payments required under Medicare Part D are considered medically necessary health services. For more information, refer to the Part 1 provider manual.

Prescription drug payments required under the Medicare Part D prescription drug program should be applied to the recipient's SOC upon receiving payment or accepting obligation for payment from the recipient. Delays in performing the SOC clearance transaction may prevent the recipient from receiving other medically needed services.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace at the end of *Manual Ordering* section:	*Subscriber Order Form* 1/2 *
Remove and replace:	child 1 thru 4 * forms reo ma 1/2 * medi non hcp 1/2 *
Remove and replace after the *Orthotic and Prosthetic Appliances* section:	*Physician Certification of Medical Necessity for Therapeutic Diabetic Shoes and Inserts* *
Remove and replace:	tar comp 1 thru 13 *
Remove:	tar sub clk 1 thru 3
Remove and replace:	tar submis 3 *
Remove: Insert:	tar submit 1/2 tar submit 1 *

* Pages updated due to ongoing provider manual revisions.